Physician-Patient Advocacy Program

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UMMG Office of Patient Protection and Risk Prevention

The complexities of a large academic medical center can impose multiple barriers to physicians' individual efforts to improve their communication and quality of patient care. In an effort to break down these barriers and to support the individual and system-based changes needed to increase patient safety and safety awareness, we created a special support program to assist providers in the clinical management and prevention of unanticipated outcomes. It is at moments of critical decision-making that we felt physicians would be most receptive and motivated to accept assistance and guidance. This program offers the opportunity to provide education based on behavioral science principles tailored to the clinical issues most relevant to a particular patient. We use a variety of support approaches and strategies depending upon the patient/ family and presenting condition. Each are based upon the core principle that timely, open, honest, and accurate communication is the most effective approach to safe patient care. Of significance, is that these lessons are now filtering through the system to change the culture on communication when things go wrong.

UMMG Physician-Patient Advocacy Program

The program is designed to provide assistance to UMMG physicians when there has been an unexpected clinical event that may negatively affect the physician's ability to maintain a positive physician-patient relationship. These services include:

1) situation management and control;
2) medical team debriefing;
3) on-site investigation and support;
4) facilitating disclosure of adverse events to the patient and family;
5) post-event clinical management and counseling of patients and families;
6) enhancing physician-to-physician communication as part of high-risk patient management;
7) litigation risk assessment of complaints from difficult patients;
8) evaluation of a patient's understanding of the risks of high risk procedures and the efficacy of informed consent with recommendations for the clinical management of the patient;
9) training programs on patient safety, communication, and "lessons learned " from event investigation and litigation.

Educational Programs

Consultation with Residency Program Directors on patient safety, leadership, communication, and professionalism to comply with ACGME competency standards.

Disclosure of Unexpected Outcomes

The Physician-Patient Advocacy Program works in close connection with the Office of Patient Protection and Risk Prevention to investigate unanticipated outcomes and assist with the post-event clinical management of patients and families. After an adverse event the Physician-Patient relationship often becomes disrupted and there is a loss of trust and confidence in the medical team. This program is intended to give physician's the resources necessary to maintain rapport with patients and family members. It promotes the maintenance of open and direct dialogue about the event and the results of our internal review and investigation. The primary goal of the program is to assure prompt compliance with the physician's legal and professional obligation to notify the patient or their designee of the adverse outcomes, to subsequently monitor the patient 's and family's understanding of the event, and to incorporate full disclosure as an essential component of safe and effective patient care.

RAPPORT PROGRAM

Rapid Assessment of Patient Perspective of Outcomes and Risk of Treatment

When consenting patients for high risk procedures it may be appropriate to request an evaluation of the patient's understanding of the risks involved and their expectations regarding potential outcomes. This program is designed to support the physician in obtaining full and informed consent to treatment of patients who may not be well known to the physician; with whom the physician may have little rapport; that have a complicated clinical picture with a history of noncompliance; or that have acted in a manner that suggests to the physician that the patient may not fully recognize the seriousness of their medical condition. The physician will be provided an evaluation report that details the patient's understanding of these risks and provides comprehensive recommendations for the effective clinical management of the patient .

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"If you shut your door to all errors, truth will be shut out"

Rabindranath Tagore

Program Snapshot

60 Referrals

Types of Events		Complexity Level
Death	Delayed diagnosis &TX	Level I: Severe (Death, Paralysis, Loss of Organ, Loss of Limb) 40%
Paralysis	Coma	
Loss of Organ/Implant	Medication Error	Level 2: Serious (wrong site, wrong patient, wrong procedure, surgical injury ,retained object) 10%
Retained Foreign Object	TX error	
Surgical Injury	Pt Conflict Team	Level 3: Important (pain management, delayed diagnosis, infection, medication errors) 18%
Multiple complications	Infection	
Cardiac Arrest	Wrong Test	Level 4: Quality of Care 10%
Wrong Procedure	Wrong Patient	
OOC	Letter of Complaint	Level 5: General (Noncompliance, over-utilization of services, disruptive patient)14%
Delivery Complications	Pain Management	
Suicide	Disruptive patient	
Brain Death		

Physician Requests	Types of Interventions
Disclosure Assistance	Assistance with Disclosure
Review Patient and Care	Consultation on Clinical Management
Resolve System Barriers	Facilitation of Patient/Family meetings
Clinical Behavioral Management	Role Play Communication
Facilitation Family Meeting	Coordination of Communication of Team
Management of Disruptive Patient	Assist RCA and Communication of Findings
Coordination Root Cause Analysis	Support Program
Communication Multiple Providers	Maintain Support and Communication with Patient/Family
Support Program	Coordination of Physician Written Communication
Patient Resource Contact	Education of Physician on Family Systems and Psychological Issues
Assistance with Written Patient Correspondence	

INTEGRATION OF CORE COMPONENTS

Communication
- Medical Team Debriefing
- Patient/Family Interviews and Advocacy
- Individual coaching and role-play
- Contact numbers on ID badge
- Disclosure Guide

Leadership
- Department Chair Involvement
- High-Risk Procedure Planning
- RCA and Peer Review
- Blame-Free Environment
- Accountability

Education
- Medical Error
- Cognitive Training
- Disclosure Training
- Empathy Training
- Risk Prevention
- Program Brochure

Facilitation
- Provider-Patient/Family Meetings
- Modeling Communication Methods
- Physician-Nursing Teambuilding

Lessons Learned

- When things go wrong patients cannot fully participate in decision-making unless physicians are able to maintain the sacred trust that is the foundation of every patient-provider relationship.
- The relationship between patients and providers has become severely strained and is often irreparably broken because the "health care industry" has become far removed from the "bedside".
- Patients would be more willing to maintain trust, even after an adverse event, if only the system gave voice to their concerns.
- Because health care providers have not given their patients an alternative, patients have sought out solutions through regulators, legislatures, consumer groups, the media, government and private payers, or the courts.
- We must give our providers a safe space in which to evaluate the issues and institutional "permission" to engage in open and honest discussions with patients and families about medical mistakes.
- The "culture shock" and lack of ready acceptance that we expected has not occurred. With only limited exception, our medical teams have embraced the concept and enthusiastically supported the program.
- The intelligence, intuition, and empathy that make our providers excellent clinicians allows them to easily cross the artificial barrier that has arisen between them and their patients once an unexpected event occurred.
- The "culture of caring" is nothing new to the profession. It simply has been masked by efforts to replace that culture with an overarching system of checks and balances intended to promote quality patient care.

The current systems approaches to quality care have not and never will replace that which is most important and fundamental to risk prevention and patient safety – the inherent trust between a patient and their healthcare providers.